Teacher Item Rationale

2010 School Health Profiles Report
Item Rationale
Lead Health Education Teacher Survey

REQUIRED HEALTH EDUCATION COURSES

QUESTIONS:

1. How many required health education courses do students take in grades 6 through 12 in your school?

2. Is a required health education course taught in each of the following grades in your school?

RATIONALE:

These questions measure the extent to which health education courses are required for students in grades 6 through 12. School health education could be one of the most effective means to reduce and prevent some of the most serious health problems in the United States, including cardiovascular disease, cancer, motor-vehicle crashes, homicide, and suicide.[(1)] The Institute of Medicine has recommended that schools require a one-semester health education course at the secondary school level;[(1)] however, the benefits of a health education curriculum increase when students receive at least three consecutive years of a quality health curriculum.[(2)]

REFERENCES:

1. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.

2. Lohrmann DK, Wooley SF. Comprehensive School Health Education. In: Marx E, Wooley SF, eds. *Health Is Academic: A Guide to Coordinated School Health Programs.* New York: Teachers College Press, 1998, pp. 43–66.

QUESTION:

3. If students fail a required health education course, are they required to repeat it?

RATIONALE:

This question measures the importance of a required health education course for students in grades 6 through 12.

QUESTION:

4. Are those who teach health education at your school provided with each of the following materials?

RATIONALE:

This question addresses the types of information and support materials health education teachers are given in order to implement health education classes. According to the Joint Committee on National Health Education Standards, quality health education is guided by access and equity principles that call for clear curriculum direction, including goals, objectives, and expected outcomes; a written curriculum; clear scope and sequence of instruction for health education content; and plans for age-appropriate student assessment.[1]

REFERENCE:

1. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition).* Atlanta, GA: American Cancer Society, 2007.

QUESTION:

5. Does your health education curriculum address each of the following?

RATIONALE:

This question addresses the extent to which schools have a health education curriculum that is based on, or is consistent with, current national health education standards.[1]

REFERENCE:

1. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition).* Atlanta, GA: American Cancer Society, 2007.

REQUIRED HEALTH EDUCATION

QUESTION:

6. Is health education instruction required for students in any of grades 6 through 12 in your school?

RATIONALE:

Not all health education instruction takes place in health education courses.[1] This question addresses whether schools require any classroom instruction on health topics, including instruction that occurs outside of health education courses.

REFERENCE:

1. Kann L, Telljohann SK, and Wooley SF. Health education: results from the School Health Policies and Programs Study 2006. *Journal of School Health.* 2007;77(8): 408-434.

QUESTION:

7. During this school year, have teachers in your school tried to increase student knowledge on each of the following topics in a required course in any of grades 6 through 12?

RATIONALE:

This question addresses the extent to which traditional health content areas and the prevention of health risk behaviors are taught in required courses in grades 6 through 12.

QUESTION:

8. During this school year, did teachers in your school teach each of the following tobacco-use prevention topics in a required course for students in any of grades 6 through 12?

RATIONALE:

This question measures the tobacco-use prevention curricula content, and relates to the *Healthy People 2010* Objective 7-2 of providing school health education to prevent health problems among middle, junior high, and high school students including those from tobacco use.[1] Since most smoking is initiated by persons less than 18 years old, programs that prevent onset of smoking during the school years are crucial.[2] School-based tobacco prevention programs that address multiple psychosocial factors related to tobacco use among youth and that teach the

skills necessary to resist those influences have demonstrated consistent and significant reductions or delays in adolescent smoking.[2-9] Social influence programming has reduced smoking onset by as much as 50%, with effects lasting up to 6 years, and with effects including reduction of the use of other tobacco products as well.[4]

In addition, this question measures the extent to which schools are complying with the components of the National Health Education Standards, which provide a framework for decisions about the lessons, strategies, activities, and types of assessment to include in a health education curriculum.[10]

REFERENCES:

1. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, 2000.

2. U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Young People: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994.

3. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.

4. Sussman S. School-based tobacco use prevention and cessation: where are we going? *American Journal of Health Behavior*. 2001;25(3):191-9.

5. Dent CW, Sussman S, Stacy AW, Craig S, Burton D, Flay BR. Two-year behavior outcomes of project towards no tobacco use. *Journal of Consulting and Clinical Psychology.* 1995;63(4):676-677.

6. Botvin GJ, Baker E, Dusenbury L, Botvin EM, Diaz T. Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. *Journal of the American Medical Association*. 1995;273(14):1106-1112.

7. Lantz PM, Jacobson PD, Warner KE, Wasserman J, Pollack HA, Berson J, Ahlstrom A. Investing in youth tobacco control: a review of smoking prevention and control strategies. *Tobacco Control*. 2000;9:47-63.

8. Rooney BL, Murray DM. A meta-analysis of smoking prevention programs after adjustment for errors in the unit of analysis. *Health Education Quarterly*. 1996;23(1):48-64.

9. Bruvold WH. A meta-analysis of adolescent smoking prevention programs. *American Journal of Public Health*. 1993;83(6):872-80.

10. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition).* Atlanta, GA: American Cancer Society, 2007.

QUESTION:

9. During this school year, did teachers in your school teach each of the following HIV, STD, or pregnancy prevention topics in a required course for students in each of the grade spans below?

RATIONALE:

These questions measure the HIV prevention curricula content. HIV and sex education programs can increase knowledge about how to avoid HIV and STD infection and unintended pregnancy. While knowledge provides a foundation for human action, knowledge alone is not sufficient to change behavior. Both knowledge and skills are important components of behavioral change.[1, 2] Thus, efforts to increase knowledge alone about modes of transmission and strategies for prevention do not directly lead to behavior change.[3] To reduce HIV, other STDs, and unintended pregnancy, programs must address perceptions of risk, intentions, communication, and skills, in addition to HIV and STD knowledge.[4]

Adolescents have different HIV prevention needs than do adults. However, because of the variability among youth with respect to cognitive and social maturity and sexual experience, interventions must be tailored to meet the unique needs of younger versus older youth or sexually naive versus experienced teens. HIV prevention interventions also have to be matched to the cognitive level of adolescents and should be designed to improve behavioral skills for risk reduction, decision making, planning, and problem solving.[5]

Part of a program's effectiveness involves its organization and presentation of activities and materials in an age appropriate and logical sequence. A typical logical sequence includes basic information about HIV, other STDs, and pregnancy, including susceptibility and severity of HIV, other STDs, and pregnancy; discussion of behaviors to reduce vulnerability; knowledge, values, attitudes and barriers related to these behaviors; and skills needed to perform these behaviors.[6] Messages in these effective programs are appropriate to the age, sexual experience, gender and culture of the youth.[4]

REFERENCES:

1. Ajzen I. From intention to actions: A theory of planned behavior. In: Kuhl J, Beckman J, eds. *Action control from cognition to behavior*. New York: Springer-Verlag, 1985, pp. 11-29.

2. Bandura A. *Social foundations of thought and action*. Englewood Cliffs, NJ: Prentice Hall, 1986.

3. Coyle SL, Boruch RF, Turner CF, eds. *Evaluating AIDS prevention programs, Expanded Edition*. Washington, DC: National Academy Press, 1991.

4. Kirby D, Laris BA, Rolleri L. *Sex and HIV education programs for youth: Their impact and important characteristics*. Washington DC: Family Health International, 2006. Available at: http://www.fhi.org/NR/rdonlyres/eg6dcdnypfc6lbcdq2jccju67o644svf3npgjtuagpsdimlkx7edlrojytwevjznjsfnkqflbak4hj/SexandHIVEducationProgramsKirby.pdf. Accessed June 11, 2009.

5. Pedlow CT, Carey MP. Developmentally appropriate sexual risk reduction interventions for adolescents: rationale, review of interventions, and recommendations for research and practice. *Annals of Behavioral Medicine.* 2004;27(3):172-184.

6. Kirby D, Rolleri L, Wilson MM. *Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs.* Washington, DC: Healthy Teen Network, 2007.

QUESTION:

10. During this school year, did teachers in your school teach each of the following nutrition and dietary behavior topics in a required course for students in any of grades 6 through 12?

RATIONALE:

This question measures the curricula content related to nutrition and dietary behavior. Comprehensive, sequential nutrition education using the classroom and the lunchroom can reinforce healthful eating behaviors.[1, 2] Nutrition education should be part of a comprehensive school health education curriculum and include concepts to promote healthy eating.[3, 4] This list of 15 nutrition topics is based on CDC guidelines[5] and the *School Health Index*.[6]

REFERENCES:

1. Food and Nutrition Board, Institute of Medicine, Committee on Prevention of Obesity of Children and Youth, Schools. In: JP Koplan, CT Liverman and VI Kraak, eds. *Preventing Childhood Obesity: Health in the Balance*. Washington, DC: National Academy Press, 2005, pp. 237–284.

2. American Dietetic Association, Society for Nutrition Education, and American School Food Service Association. Nutrition services: an essential component of comprehensive school health programs. *Journal of Nutrition Education and Behavior.* 2003;35(2):57-67.

3. Ralston K, Buzby J, Guthrie J. *A Healthy School Meal Environment.* United States Department of Agriculture, Economic Research Service, Food Assistance and Nutrition Research Report Number 34-5, 2003. Available at: http://www.ers.usda.gov/publications/fanrr34/fanrr34-5/fanrr34-5.pdf. Accessed June 8, 2009.

4. U.S. Department of Agriculture. *Changing the Scene: Improving the School Nutrition Environment.* 2000. Available at: http://www.fns.usda.gov/tn/Resources/changing.html. Accessed June 8, 2009.

5. CDC. Guidelines for school health programs to promote lifelong healthy eating. *MMWR.* 1996;45(RR-9):1-33.

6. CDC. *School health index.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2006. Available at: http://www.cdc.gov/healthyyouth/shi. Accessed June 8, 2009.

QUESTION:

11. During this school year, did teachers in your school teach each of the following physical activity topics in a required course for students in any of grades 6 through 12?

RATIONALE:

This question measures the extent to which physical activity concepts are taught in a required health education course. Health education that includes physical activity concepts increases the likelihood of students increasing their participation in physical activity,(1) reinforces what has been taught in physical education,(2) and assists students in achieving the National Health Education Standards.(3)

REFERENCES:

1. Hoelscher D, Feldman H, Johnson C, et al. School-based health education programs can be maintained over time: results from the CATCH institutionalization study. *Preventive Medicine.* 2004;38(5):594-606.

2. Pate RR, Davis MG, Robinson TN, Stone EJ, McKenzie TL, Young JC. Promoting physical activity in children and youth: a leadership role for schools. *Circulation.* 2006;114:1-11.

3. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition).* Atlanta, GA: American Cancer Society, 2007.

HIV PREVENTION

QUESTION:

12. During this school year, did your school provide any HIV, STD, or pregnancy prevention programs for ethnic/racial minority youth at high risk (e.g. black, Hispanic, or American Indian youth), including after-school or supplemental programs, that did each of the following?

RATIONALE:

This question measures whether a school addresses HIV, other STD, and pregnancy prevention through targeted efforts reaching those identified as most at-risk. Risk for HIV infection is especially notable for youth of minority races and ethnicities. African-Americans are the largest group of people affected by HIV/AIDS, accounting for 51% of all HIV/AIDS cases diagnosed in 2007.(1) And, although only 17% of teenagers (ages 13-19) in the United States are African-Americans, they accounted for 72% of new HIV/AIDS cases diagnosed in 34 states with confidential name-based reporting among teens in 2007.(2) In 2004, HIV/AIDS was the number one cause of death for African-American women aged 25-34 years and the number three cause of death for all African- Americans aged 35-44.(3) In addition, the HIV/AIDS epidemic is a serious threat to the Hispanic/Latino community. Hispanics/Latinos comprise 15% of the U.S. population, but accounted for 17% of all new HIV infections occurring in the United States in 2006. During the same year, the rate of new HIV infections among Hispanics/Latinos was three times that of whites.(4)

Data from CDC's 2007 National Youth Risk Behavior Survey (YRBS) show that, compared with white students and Hispanic/Latino students, black students have the highest rates of several sexual risk behaviors: 66.5% of black students had ever had sexual intercourse, compared with 43.7% percent of white students and 52.0% of Hispanic/Latino students; 46.0% of black students were currently sexually active (i.e., had sexual intercourse with 1 or more persons during the 3 months preceding the survey), compared with 32.9% of white students and 37.4% of Hispanic/Latino students; 16.3% of black students had had sexual intercourse before age 13 years, compared with 4.4% of white students and 8.2% of Hispanic/Latino students; and 27.6% of black students had had sexual intercourse with 4 or more persons during their life, compared with 11.5% of white students and 17.3% of Hispanic/Latino students.(5)

In addition to effective curricula, access to valid information and products, as well as access or referral to health, social, and psychological services to prevent HIV, other STDs, and pregnancy are especially important in ethnic/racial minority communities where the higher prevalence of HIV, other STDs, and pregnancy reflects both risky adolescent sexual behaviors and system barriers to quality prevention services.(6) Factors which may influence adolescents' access to care include health insurance, cost, convenience, confidentiality, and demographic factors such as age, gender, and ethnicity.(7-9)

REFERENCES:

1. CDC. *HIV/AIDS Surveillance Report, 2007*. Vol. 19. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2009. Available at: http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/pdf/2007SurveillanceReport.pdf. Accessed June 8, 2009.

2. CDC. *HIV/AIDS Surveillance in Adolescents and Young Adults (through 2007)*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2009. Available at: http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm. Accessed June 8, 2009.

3. Heron MP. Deaths: Leading causes for 2004. *National Vital Statistics Reports.* 2007;56(5):1-96.

4. Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. *JAMA*. 2008;300:520–529.

5. CDC. Youth risk behavior surveillance—United States, 2007. *MMWR.* 2008;57(SS-4):1–131.

6. Gilliland L, Scully, J. STI-HIV prevention: a model program in a school-based health center. *Nursing Clinics of North America.* 2005;40:681-688.

7. Ginsburg KR, Slap GB, Cnaan A, et al. Adolescents' perceptions of factors affecting their decisions to seek future healthcare. *JAMA.* 1995;273:1913-8.

8. Ford CA, Millstein SG, Halpern-Felsher BL, Irwin CE. Influence of physican confidentiality assurances on adolescents' willingness to disclose information and seek future healthcare. *JAMA.* 1997;278:1029-34.

9. Lieu T, Newacheck P, McManus M. Race, ethnicity, and access to ambulatory care among U.S. adolescents. *American Journal of Public Health.* 1993;83:960-5.

QUESTION:

13. Does your school provide curricula or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to lesbian, gay, bisexual, transgender, and questioning youth (e.g., curricula or materials that use inclusive language or terminology)?

RATIONALE:

This question assesses whether the school uses inclusive curricula or supplementary materials for lesbian, gay, bisexual, transgender, and questioning youth. Some students who engage in same-sex sexual behavior are at greater risk for HIV, STD, and unintended pregnancy.[1] Furthermore, research indicates reduced risk behaviors for some lesbian, gay, and bisexual youth when using inclusive HIV instruction in schools.[2]

REFERENCES:

1. Garofalo R, Katz E. Health care issues of gay and lesbian youth. *Current Opinion in Pediatrics.* 2001;13(4):298-302

2. Blake SM, Ledsky R, Lehman T, Goodenow C, Sawyer R, Hact T. Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: the benefits of gay-sensitive HIV instruction in schools. *American Journal of Public Health.* 2001;91(6):940-946.

COLLABORATION

QUESTION:

14. During this school year, have any health education staff worked with each of the following groups on health education activities?

RATIONALE:

This question measure the extent to which health education staff work cooperatively with other components of the school health program (school health services, school mental health or social services, food service, and physical education staff). An integrated school and community approach is an effective strategy to promote adolescent health and well being.[1]

REFERENCE:

1. Allensworth D, Kolbe L. The comprehensive school health program: state of the art. *Journal of School Health.* 1987;63:14–20.

QUESTION:

15. During this school year, did your school provide parents and families with health information designed to increase parent and family knowledge of each of the following topics?

RATIONALE:

This question measures whether schools are providing health information to students' families. School programs that engage parents and link with the community yield stronger positive results. Studies aimed at preventing childhood overweight, treating childhood overweight, and promoting physical activity and healthy eating have demonstrated more success when targeting the parent and child versus targeting the child alone.[1, 2] School-based tobacco prevention programs and community interventions involving parents and community organizations have a stronger impact over time when working in tandem rather than as separate, stand-alone interventions.[3] Assessments of successful school-based asthma management programs indicate that with increased knowledge, parents can assist their children in better managing their asthma.[4-6] Parents also are teenagers' primary sex educators, able to capitalize on teachable moments when youth may be more open to learning new information.[7] Parents can continue prevention messages delivered in school, thereby enhancing the likelihood of sustained behavioral changes.[8] Increased communication affects both parenting and health practices of parents. Communicating information on healthy lifestyles aims to reinforce the child's coursework at school, facilitate communication with parents about school activities, and increase parent knowledge of healthy living.[9, 10]

REFERENCES:

1. Golan M, Crow S. Targeting parents exclusively in the treatment of childhood obesity: long-term results. *Obesity Research.* 2004;12:357-361.

2. Epstein LH, Voloski A, Wing RR, McCurley J. Ten-year outcomes of behavioral family-based treatment for childhood obesity. *Health Psychology.* 1994;13:373-83.

3. Lantz PM, Jacobson PD, Warner KE, Wasserman J, Pollack HA, Berson J, Ahlstrom A. Investing in youth tobacco control: a review of smoking prevention and control strategies. *Tobacco Control.* 2000;9:47-63.

4. Splett PL, Erickson CD, Belseth SB, Jensen C. Evaluation and sustainability of the healthy learners asthma initiative. *Journal of School Health.* 2006;76(6):276-282.

5. Erickson, CD, Splett PL, Mullett SS, Jensen C, Belseth SB. The healthy learner model for student chronic condition management-Part II: The Asthma Initiative. *Journal of School Nursing.* 2006;22(6):319-329.

6. Levy M, Heffner B, Stewart T, Beeman G. The efficacy of asthma case management in an urban school district in reducing school absences and hospitalizations for asthma. *Journal of School Health.* 2006;76(6):320-324.

7. Szapocznik J, Coatsworth JD. An ecodevelopmental framework for organizing risk and protection for drug abuse: A developmental model of risk and protection. In: Glantz M, Hartel CR, eds. *Drug Abuse: Origins and Interventions*. Washington, DC: American Psychological Association, 1999, pp. 331-366.

8. Pequegnat W, Szapocznik J. The role of families in preventing and adapting to HIV/AIDS: Issues and answers. In: Pequegnat W, Szapocznik J, eds. *Working with families in the era of HIV/AIDS.* Thousand Oaks, CA: Sage Publications, 2000.

9. Nader PR, Sellers De, Johnson CC, Perry CL, Stone EJ, Cook KC, Bebchuk J, Luepker RV. The effect of adult participation in a school-based family intervention to improve children's diet and physical activity: the Child and Adolescent Trial for Cardiovascular Health. *Preventive Medicine.* 1996;25:455-464.

10. Perry CL, Luepker RV, Murray DM, Kurth C, Mullis R, Crockett S, Jacobs DR. Parent involvement with children's health promotion: the Minnesota Home Team. *American Journal of Public Health.* 1988;78(9):1156-1160.

PROFESSIONAL DEVELOPMENT

QUESTION:

17. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics? (HIV)

RATIONALE:

This question measures the extent to which professional development has been received by the lead health teacher responsible for teaching about HIV/AIDS. As new information and research on prevention is available, those responsible for teaching about HIV/AIDS should periodically receive continuing education about HIV and other STD infections to assure they have the most current information about how widespread HIV and other STDs are, effective prevention and health education intervention strategies, and priority populations identified as most at-risk for HIV and other STD infection.[1-3]

Effective implementation of school health education is linked directly to adequate teacher training programs.[4] School health education designed to decrease students' participation in risk behaviors requires that teachers have appropriate training to develop and implement school health education curricula.[4] Staff development activities for health education teachers need to focus on teaching strategies that both actively engage students and facilitate their mastery of critical health information and skills.[5]

REFERENCES:

1. Kirby D, Laris BA, Rolleri L. *Sex and HIV education programs for youth: Their impact and important characteristics*. Washington, DC: Family Health International, 2006. Available at: http://www.fhi.org/NR/rdonlyres/eg6dcdnypfc6lbcdq2jccju67o644svf3npgjtuagpsdimlkx7edlrojytwevjznjsfnkqflbak4hj/SexandHIVEducationProgramsKirby.pdf. Accessed June 11, 2009.

2. Center for AIDS Prevention Studies (CAPS) and the AIDS Research Institute, University of California, San Francisco. *What Works Best in Sex/HIV Education?* San Francisco: University of California San Francisco, 2006.

3. Council of Chief State School Officers. *What Education Leaders Should Know About Forming Partnerships to Prevent Sexual-Risk Behaviors in School-Aged Youth.* Washington, DC: Author, 2005.

4. Allensworth, D. Health education: state of the art. *Journal of School Health.* 1993;63:14–20.

5. National Commission on the Role of the School and the Community to Improve Adolescent Health. *Code Blue: Uniting for Healthier Youth*. Alexandria, VA: National Association of State Boards of Education, 1990.

QUESTIONS:

16. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics?

18. Would you like to receive professional development on each of the following topics?

19. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics?

20. Would you like to receive professional development on each of these topics?

RATIONALE:

These questions address the importance of professional development for teachers. It is vitally important that teachers be well prepared when they begin teaching and that they continue to improve their knowledge and skills throughout their careers.[(1)] Educators who have received professional development in health education report increases in the number of health lessons taught and their confidence in teaching.[(2)] Professional development increases educators'

confidence in teaching subject matter and provides opportunities for educators to learn about new developments in the field and innovative teaching techniques, and to exchange ideas with colleagues.[3,4] Districts that have made improvements in their professional development activities have seen a rise in student achievement.[5, 6] Staff development is associated with increased teaching of important health education topics.[7] The Institute of Medicine's Committee on Comprehensive School Health Programs in Grades K-12 recommended that health education teachers should be expected to participate in ongoing, discipline-specific in-service programs in order to stay abreast of new developments in their field.[8]

REFERENCES:

1. Public Education Network. *Teacher Professional Development: A Primer for Parents and Community Members*. Washington, DC: Public Education Network, 2004.

2. Hausman A, Ruzek S.. Implementation of comprehensive school health education in elementary schools: focus on teacher concerns. *Journal of School Health.* 1995;65(3):81-86.

3. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.

4. National Association of State Boards of Education (NASBE) & National School Boards Association (NSBA). *HIV Prevention in Schools: A Tool Kit for Education Leaders*. 2002. Available at: http://nasbe.org/index.php/file-repository?func=startdown&id=787. Accessed June 12, 2009.

5. Togneri W, Anderson SE. *Beyond Islands of Excellence: What Districts Can Do to Improve Instruction and Achievement in all Schools.* Washington, DC: Learning First Alliance, 2003.

6. Miles KH, Darling-Hammond L. *Rethinking the Allocation of Teaching Resources: Some Lessons From High-Performing Schools.* Philadelphia: Consortium for Policy Research in Education, 1997.

7. Jones SE, Brener ND, McManus T. The relationship between staff development and health instruction in schools in the United States. *American Journal of Health Education.* 2004;35:2-10.

8. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.

PROFESSIONAL PREPARATION

QUESTIONS:

21. What was the major emphasis of your professional preparation?

22. Currently, are you certified, licensed, or endorsed by the state to teach health education in middle school or high school?

23. Including this school year, how many years of experience do you have teaching health education courses or topics?

RATIONALE:

These questions measure the extent to which lead health education teachers are formally trained in the topic of health education as well as the teaching experience and credentials of the lead health education teacher. Health education teachers need to be academically prepared and specifically qualified on the subject of health.[1] In addition, pre-service training in health education is associated with increased teaching of important health education topics.[2]

REFERENCES:

1. National Commission on the Role of the School and the Community to Improve Adolescent Health. *Code Blue: Uniting for Healthier Youth*. Alexandria, VA: National Association of State Boards of Education, 1990.

2. Jones SE, Brener ND, McManus T. The relationship between staff development and health instruction in schools in the United States. *American Journal of Health Education.* 2004;35:2-10.